

Measles Surveillance Worksheet

NAME (Last, First)			Hospital Record No.		
Address (Street and No.)		City	County	Zip	Phone
Reporting Physician/Nurse/Hospital/Clinic/Lab Address				Phone	

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Measles Surveillance Worksheet

County		State		Zip	
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Birth Date <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Age <input type="text"/> <input type="text"/> Unk = 999		Age Type <input type="checkbox"/> 0 = 0-120 years <input type="checkbox"/> 1 = 0-11 months <input type="checkbox"/> 2 = 0-62 weeks <input type="checkbox"/> 3 = 0-28 days <input type="checkbox"/> 9 = Age unknown		Ethnicity <input type="checkbox"/> H = Hispanic <input type="checkbox"/> N = Not Hispanic <input type="checkbox"/> U = Unknown		Race <input type="checkbox"/> N = Native Amer./Alaskan Native <input type="checkbox"/> A = Asian/Pacific Islander <input type="checkbox"/> B = African American		Sex <input type="checkbox"/> M = Male <input type="checkbox"/> F = Female <input type="checkbox"/> U = Unknown			
Event Date <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Event Type <input type="checkbox"/> 1 = Onset Date <input type="checkbox"/> 2 = Diagnosis Date <input type="checkbox"/> 3 = Lab Test Done		<input type="checkbox"/> 4 = Reported to County <input type="checkbox"/> 5 = Reported to State or MMWR Report Date <input type="checkbox"/> 9 = Unknown		Outbreak Associated <input type="text"/> <input type="text"/> <input type="text"/> Unk = 999		Reported <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Imported <input type="checkbox"/> 1 = Indigenous <input type="checkbox"/> 2 = International <input type="checkbox"/> 3 = Out of State <input type="checkbox"/> 9 = Unknown		Report Status <input type="checkbox"/> 1 = Confirmed <input type="checkbox"/> 2 = Probable <input type="checkbox"/> 3 = Suspect <input type="checkbox"/> 9 = Unknown	

Any Rash? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Rash Onset <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Rash Duration <input type="text"/> <input type="text"/> <input type="text"/> 0 - 30 Days 99 = Unknown		Otitis? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Diarrhea? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Pneumonia? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Encephalitis? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	
Rash Generalized? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Fever? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		If Recorded, Highest Measured Temp. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 36.0 - 110.0 Degrees 999.9 = Unknown		Thrombocytopenia? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Died? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Other Complications? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown If Yes, Please Specify:			
Cough? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Coryza? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Conjunctivitis? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Hospitalized? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Days Hospitalized <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 - 999 999 = Unknown					

Was Laboratory Testing For Measles Done? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown				Vaccinated? (Received measles-containing vaccine?) <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown				If Not Vaccinated, What Was The Reason? (See Reason Codes Below)			
Date IgM Specimen Taken <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year				Result <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> I = Indeterminate				<input type="checkbox"/> E = Pending <input type="checkbox"/> X = Not Done <input type="checkbox"/> U = Unknown			
Date IgG Acute Specimen Taken <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year				Result <input type="checkbox"/> P = Significant Rise in IgG <input type="checkbox"/> N = No Significant Rise in IgG <input type="checkbox"/> I = Indeterminate				<input type="checkbox"/> E = Pending <input type="checkbox"/> X = Not Done <input type="checkbox"/> U = Unknown			
Date IgG Convalescent Specimen Taken <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year				Other Lab Result <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> I = Indeterminate				<input type="checkbox"/> E = Pending <input type="checkbox"/> X = Not Done <input type="checkbox"/> U = Unknown			
Specify Other Lab Method:				Number of doses received BEFORE 1st birthday <input type="text"/>				Number of doses received ON or AFTER 1st birthday <input type="text"/>			
Date First Reported to a Health Department <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year				Date Case Investigation Started <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year				Reason Codes 1 = Religious Exemption 2 = Medical Contraindication 3 = Philosophical Objection 4 = Lab. Evidence of Previous Disease 5 = MD Diagnosis of Previous Disease 6 = Under Age For Vaccination 7 = Parental Refusal 8 = Other 9 = Unknown			
Transmission Setting (Where did this case acquire measles?) <input type="checkbox"/> 1 = Day Care <input type="checkbox"/> 2 = School <input type="checkbox"/> 3 = Doctor's Office <input type="checkbox"/> 4 = Hospital Ward <input type="checkbox"/> 5 = Hospital ER <input type="checkbox"/> 6 = Hospital Outpatient Clinic <input type="checkbox"/> 7 = Home <input type="checkbox"/> 8 = Work <input type="checkbox"/> 9 = Unknown <input type="checkbox"/> 10 = College <input type="checkbox"/> 11 = Military <input type="checkbox"/> 12 = Correctional Facility <input type="checkbox"/> 13 = Church <input type="checkbox"/> 14 = International Travel <input type="checkbox"/> 15 = Other				Outbreak Related? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown				If Yes, Outbreak Name			
Were Age and Setting Verified? (Is age appropriate for setting, i.e. under 16 and in school, etc.) <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown				If Transmission Setting Not Among Those Listed And Known, What Was The Transmission Setting?				Source of Exposure For Current Case Enter State ID if source was an in-state case Enter Country if source was out of USA Enter State if source was out-of-state			
Epi-Linked to Another Confirmed or Probable Case? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown				Is Case Traceable Within 2 Generations to an International Import? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown							

Note: This form has 2 sides

Indicates epidemiologically important items not yet on NETSS screen

Contact Information: (for state/local health department use)

Mother's Name

Father's Name

Phone

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The information below is epidemiologically important, but not included on NETSS screens

Activity History For 18 Days Before Rash Onset And 7 Days After Rash Onset

Day -18

Day -17

Day -16

Day -15

Day -14

Day -13

Day -12

Day -11

Day -10

Day -9

Day -8

Day -7

Day -6

Day -5

Day -4

Day -3

Day -2

Day -1

Day 0 (Rash Onset)

Day 1

Day 2

Day 3

Day 4

Day 5

Day 6

Day 7

Clinical Case Definition*:

A generalized rash lasting ≥ 3 days, a temperature ≥ 101.0 F (≥ 38.3 C), and cough, coryza, or conjunctivitis.

Case Classification*:

Suspected: Any febrile illness accompanied by rash.

Probable: A case that meets the clinical case definition, has noncontributory or no serologic or virologic testing, and is not epidemiologically linked to a confirmed case.

Confirmed: A case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a confirmed case.
A laboratory-confirmed case does not need to meet the clinical case definition.